2-000 Client Participation and Enrollment - Basic Benefits Package

2-001 Mandatory and Excluded Clients

2-001.01 Mandatory for the Basic Benefits Package: The following Medicaid-eligible clients are required to participate in the NHC, if the client's eligibility assistance case is managed by the Health and Human Services (HHS) District Office in the designated coverage areas, unless excluded in 482 NAC 2-001.03.

1. Clients participating in the Aid to Dependent Children Program - Grant/Medical (see Title 468 NAC). For purposes of the NHC, this includes clients participating in the Medical Assistance Programs for Children (i.e., Ribicoff), Medical Assistance for Children (MAC), School Age Medical (SAM) and Kids Connection (see Title 477 NAC);
2. Clients participating in the Aid to Aged, Blind, and Disabled Program - Grant/Medical (see Title 469 NAC); and
3. Clients participating in the Child Welfare Payments and Medical Services Program (i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases) (see Title 479).

The client's managed care status (mandatory or excluded) is determined by an automated interface between the Department's eligibility system and the Managed Care File, and is based on information entered on the eligibility system by the Health and Human Services' local office staff, and known at the time of the managed care determination (see 482-000-2, NHC Determination Logic).

2-001.02 Designated Coverage Area for the NHC Basic Benefits Package: For purposes of the Basic Benefits Package, the designated coverage area includes those mandatory clients whose eligibility assistance case is managed by the Health and Human Services (HHS) Office, primarily in Douglas and Sarpy Counties in the Eastern HHS District Office (commonly referred to as District 8), and in the Southeastern District Office, primarily in Lancaster County (commonly referred to as District 7).

The NHC provides for a Primary Care Case Management (PCCM) Network (see 482 NAC 1-004) and Health Maintenance Organization (HMO) (see 482 NAC 1-004) participation in the designated coverage area for the provision of the Basic Benefits Package.

Enrollment Broker Services (EBS) for the designated coverage area is provided through a contracted entity and discussed in 482 NAC 2-000 and 3-000.

The Mental Health and Substance Abuse (MH/SA) Services component of the NHC is provided on a statewide basis as a carve-out from the Basic Benefits Package and discussed in 482 NAC 5-000.

2-001.03 Excluded Clients: The following clients are excluded from the NHC (based on the information known to the HHS eligibility system):

1. Clients with Medicare coverage;
2. Clients residing in nursing facilities and receiving custodial care (see 471 NAC 12-000 and 482 NAC 2-004.04);
3. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) (see 471 NAC 31-000);
4. Clients who are residing out-of-state or who are considered to be out-of-area (i.e., children who are placed with relatives out-of-state, and who are designated as such by HHS personnel);
5. Certain children with disabilities who are receiving in-home services (also known as the Katie Beckett program) (see 469 NAC 2-010.01F);
6. Aliens who are eligible for Medicaid for an emergency condition only (see Titles 468, 469, 477, 479 NAC);
7. Clients participating in the Refugee Resettlement Program - Grant/Medical (see Title 470 NAC);
8. Clients receiving services through the following home and community-based waivers (see Title 480 NAC) for -
    a. Adults with mental retardation or related conditions;
    b. Aged persons or adults or children with disabilities;
    c. Children with mental retardation and their families;
    d. Infants and toddlers with disabilities (also known as the Early Intervention Waiver); and
    e. Any other group for whom the Department has received approval of a 1915(c) waiver of the Social Security Act;
9. Clients who have excess income (i.e., spenddown - met or unmet) (see 471 NAC 3-000);
10. Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state (see 469 NAC);
11. Clients participating in the State Disability Program (see Title 469 NAC);
12. Clients eligible during the period of presumptive eligibility (see 471 NAC 28-000);
13. Transplantation recipients (see 471 NAC 10-000 and 482 NAC 2-004);
14. Clients who have received a disenrollment/waiver of enrollment (see 482 NAC 2-004); and
15. Clients with private health insurance for medical/surgical benefits determined to be qualified coverage or whose insurance coverage is pending verification. Qualified coverage includes verified standard comprehensive coverage, verified HMO or prepaid plan with specified providers, or verified CHAMPUS. Note: Clients with private health insurance will be excluded from NHC until the coverage is verified. Clients determined not to have qualified coverage will be required to participate in NHC (see 471 NAC 3-000). This exemption does not apply to the MH/SA services component of the NHC.

Medicaid coverage for clients excluded from NHC participation remains on a fee-for-service basis. Clients who are excluded from NHC cannot voluntarily enroll in the NHC.

Due to changes in a client's Medicaid eligibility and managed care status, a client's status may periodically change. The medical/surgical and MH/SA plan is responsible for the provision of the NHC Benefits Package for the client as long as s/he is identified as a member of his/her medical/surgical plan.

2-002 Enrollment for the NHC Basic Benefits Package

2-002.01 Purpose of Enrollment Process: The Department maintains responsibility for the enrollment of clients into managed care, through various departmental and contractual arrangements. The use of an enrollment broker precludes any direct enrollment activities by the medical/surgical plan. The major focus of the enrollment broker services (EBS) is the enrollment of the mandatory managed care clients into the Basic Benefits Package in the Designated Coverage Areas as defined in 482 NAC 1-004.

The enrollment broker services are intended to assist the client in understanding enrollment requirements and participation in the NHC. To facilitate this effort, the medical/surgical plan is required to have an understanding of the client population and the NHC enrollment processes, and to assist the Department and the enrollment broker in providing adequate information to the client about the medical/surgical plan's participation. The medical/surgical plan is also required to work cooperatively with the Department and EBS to resolve issues relating to client participation and enrollment processes, and to have the technological capability and resources available to interface with the Department's support systems.

2-002.02 Process at Initial Eligibility Interview: HHS local office staff shall provide the client with written information about the NHC when the individual applies for assistance.

At the time of the initial eligibility interview, HHS local office staff shall inform the client of the requirement to participate in the NHC.

(See 482-000-3, Initial Introductory NHC Information.)

2-002.03 Enrollment Activities: The client shall complete the following activities after receiving NHC information from the EBS:

1. Complete the health assessment. Information from the health assessment is shared with the medical/surgical plan according to Department regulations (see 482-000-4, Health Assessment); and
2. Choose a Primary Care Physician (PCP) and medical/surgical plan. Note: Family members may select different PCP and medical/surgical plans but will be encouraged to choose the same medical/surgical plan (see 482 NAC 2-002.03D, Enrollment of a Pregnant Woman and Her Unborn).

Selection of a PCP, medical/surgical plan and all enrollment activities must be completed and entered on the Managed Care File by the EBS within forty-five calendar days following a determination of eligibility, i.e., the client's case is entered on the Department's eligibility system as an active case. After forty-five calendar days, if a choice has not been made, automatic assignment (see 482 NAC 2-002.06) shall be completed by the Department and shall occur the first month possible, given system cutoff. Enrollment activities may be completed via face-to-face contact, telephone call, or by mail.

The medical/surgical plan shall agree to accept Medicaid clients in the order in which they are enrolled through the EBS.

The client shall have the opportunity to choose the PCP and medical/surgical plan of his/her choice, to the extent possible and appropriate.

Enrollment in the NHC is prospective, and is activated the first month possible, given system cutoff.

(See 482-000-5, Sample Screens from the Managed Care File - Documentation and Enrollment System.)

2-002.03A Reenrollment: If the client is re-enrolling in NHC within two months of the disenrollment, the client shall automatically be enrolled with the previous PCP and medical/surgical plan, effective with the first month possible given system cutoff. The client may be asked by the EBS to review the previously completed health assessment following the reenrollment. The Department shall send the client notification of the re-enrollment. The client is free to choose a different PCP and medical/surgical plan; however, the reenrollment process is automatic and is activated prospectively unless the client contacts the EBS. The client's choice take precedence over the systematic process, if the choice is made before system cutoff.

For example, the client loses mandatory status effective October. The client is fee-for-service during the month of October and November. If the client becomes mandatory again prior to the system cutoff in November, s/he will be reenrolled with his/her previous PCP and medical/surgical plan (if available) effective December.

Reenrollment beyond two months will be based on client choice. The EBS shall contact the client and discuss enrollment back into the NHC.

(See 482-000-6, Reenrollment Procedure Guide.)

2-002.03B Enrollment for the Clients who are Blind/Disabled and Departmental Ward/Foster Care Clients: The following procedures apply for clients who are eligible for assistance in the Blind/Disabled categories, or who are Departmental Wards or in Foster Care.

2-002.03B1 Blind/Disabled Clients: The EBS shall outreach to the blind/disabled clients who are mandatory for NHC with letters and telephone contacts (as appropriate, depending upon the needs of the client), according to standard enrollment requirements. A client who is blind/disabled will be excluded from auto-assignment. After completing the full enrollment process, the EBS shall make one last outreach attempt by sending the client a pre-nomination letter identifying a potential PCP and medical/surgical plan based on information known about the client on the eligibility and claims history file. The client shall have an additional fifteen calendar days from the date of the pre-nomination letter to make a change in the proposed PCP and medical/surgical plan. If the client does not make a change, the EBS shall activate the enrollment the first month possible, given system cutoff.

In some cases, the EBS may delay the activation of the client's enrollment for an additional thirty-day period to allow the EBS to coordinate necessary services with the prospective PCP and medical/surgical plan.

If the EBS determines that the client does not have any medical issues that need immediate attention by the PCP and medical/surgical plan, the enrollment may be activated immediately following completion of the enrollment activities described above.

The EBS shall complete the enrollment activities by entering the information on the Managed Care File and contacting the PCP and medical/surgical plan, to alert them to any immediate medical or social issues.

The EBS shall track the extended activation period, and reporting such activity to the Department.

2-002.03B2 Departmental Wards/Foster Care Clients: The EBS shall coordinate enrollment activities with the Department's Protection and Safety (PS) worker responsible for the case management of the ward/foster child. The worker shall work with the client and the client's family or legal representative, as appropriate, to complete the health assessment and explore the most appropriate choice of PCP and medical/surgical plan. See 482 NAC 2-002.03.

The PS worker shall notify the EBS of the choice of PCP and medical/surgical plan at the time the health assessment is completed.

The EBS shall work with the PS worker to outreach to the Department ward/foster care client who is mandatory for NHC with letters and telephone contacts (as appropriate, depending upon the needs of the client), according to standard enrollment requirements. A Department ward/foster care client will be excluded from auto-assignment. After completing the full enrollment process, the EBS shall make one last outreach attempt by sending the client a pre-nomination letter identifying a potential PCP and medical/surgical plan based on information known about the client on the eligibility and claims history file. The client shall have an additional fifteen calendar days from the date of the pre-nomination letter to make a change in the proposed PCP and medical/surgical plan. If the client does not make a change, the EBS shall activate the enrollment the first month possible, given system cutoff.

In some cases, the EBS may delay the activation of the client's enrollment for an additional thirty day period to allow the EBS to coordinate necessary services with the prospective PCP and medical/surgical plan.

If the EBS determines that the client does not have any medical issues that need immediate attention by the PCP and medical/surgical plan, the enrollment may be activated immediately following completion of the enrollment activities described above.

The EBS shall complete the enrollment activities by entering the information on the Managed Care File and contacting the PCP and medical/surgical plan to alert them to any immediate medical or social issues.

2-002.03C Enrollment of the Unborn When the Mother is Ineligible: When enrolling an unborn child whose mother is ineligible, the EBS shall focus the enrollment activities on the unborn. Depending on the mother's preference, a pediatrician, family practitioner or general practitioner will be selected as the PCP for the unborn. The medical/surgical plan of the unborn will be responsible for any necessary referrals for pregnancy-related services for the mother. This provision applies through the postpartum period, defined as the end of the month in which the 60th day following the end of the pregnancy occurs. The EBS shall notify the medical/surgical plan and coordinate the PCP selection and immediate referrals for the mother.

2-002.03D Enrollment of a Pregnant Woman and Her Unborn Child for the Basic Benefits Package: During the enrollment process, an eligible pregnant woman is required to choose the same medical/surgical plan, but not necessarily the same PCP, for herself and her eligible unborn/newborn child. Enrollment changes (i.e., to a different medical/surgical plan or PCP) may be made as often as allowed for any other client participating in the NHC, as long as mother and unborn/newborn are both enrolled with the same medical/surgical plan.

The requirement for mother and unborn/newborn to be in the same medical/surgical plan extends through the postpartum period, defined as the end of the month in which the 60th day following the end of pregnancy occurs.

2-002.03D1 Good Cause Exception: The mother and unborn/newborn may be enrolled in separate medical/surgical plans when requested by the client based on good cause (see 482-000-7, Mother and Unborn/Newborn Good Cause Procedure Guide). Good cause includes, but is not limited to, situations in which one medical/surgical plan is unable to meet the needs of both clients despite reasonable efforts to accommodate their needs:

1. The client has sufficient documentation to establish that the condition or illness would be better treated by a PCP and medical/surgical plan different from that of her unborn/newborn;
2. The client has sufficient documentation to establish that the client/provider relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
3. The client and the unborn/newborn have separate PCPs in different medical/surgical plans, and one of the PCPs has retired, left the practice, died, etc., and the mother does not want to disrupt the other's relationship.
4. Travel distance substantially limits the client's ability to change to a PCP in another medical/surgical plan and will create a hardship on the client in following through with the PCP services/referrals;
5. The medical/surgical plan does not have any PCPs in its network with special qualifications, as demonstrated by objective credentialling standards and standards for the care and management, to treat a particular condition;
6. The medical/surgical plan has not made reasonable efforts to locate another more appropriate PCP and/or specialists within its network;
7. The client demonstrates that the PCP and/or medical/surgical plan does not have the requisite skills and training to furnish the care and that s/he has made reasonable efforts to attempt to enlist additionally consultation; and
8. The client demonstrates that the PCP has been or will be unable, based on objective evidence, to establish a relationship with a client.

The client shall contact the Enrollment Broker Services (EBS) to request the good cause exception. The EBS shall document the client's request and reason(s) for the request and submit the information to the Department within two working days of the request. The Department shall approve or deny the request within five working days. The Department shall notify the EBS, the client, the PCP and medical/surgical plan of the approval or denial of the request.

The client may request a transfer at anytime, but when the request involves two separate medical/surgical plans for the mother and the unborn/newborn, the EBS shall discuss the same medical/surgical plan requirement with the mother and discuss the benefits of having the same PCP and medical/surgical plan.

The EBS shall assist the client in selecting a new PCP or medical/surgical plan by:

1. Discussing the reasons for requesting different PCPs and/or medical/surgical plans for the mother and unborn/newborn, and attempting to resolve any issues, when in the client's best interest;
2. Reviewing the client's needs to facilitate the client's choice of PCP or medical/surgical plan; and
3. Including the requested medical/surgical plan(s) in resolving issues such as referral/specialty service requirements, hospital affiliations of the medical/surgical plan, member services, etc.

The EBS shall also discuss the following:

1. The importance of maintaining the same medical home (i.e., PCP and medical/surgical plan) for the mother and the unborn/newborn;
2. How the client's medical care may be affected by having separate PCPs and/or medical/surgical plans;
3. That outstanding services may require additional referrals/authorizations in order to maintain the continuation of medical care; and
4. Other coordination of care issues.

The transfer will be effective the month following the request, providing the request is received/completed prior to system cutoff, but no later than the second month following the request.

The EBS shall not discourage a client from completing the transfer; rather, guide the client in exploring his/her options.

If a mother requests a transfer, the EBS shall process the transfer and enter the information on the Managed Care File (see 482-000-5). The Department shall issue a notice of finding to the client or his/her legal representative when the transfer is completed; the PCP and medical/surgical plan will be notified via the enrollment report.

Any enrollment/transfer for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-20).

In limited situations, when a PCP cannot provide care for a client, the medical/surgical plan shall arrange for an interim PCP with a given month of enrollment. These transfers are handled on a case-by-case basis between the EBS, medical/surgical plan, and the client and are considered a "client requested" transfer.

The PCP and medical/surgical plan shall maintain responsibility for providing the NHC benefits to the client until a transfer is completed.

The medical/surgical plan may work with the EBS to resolve any issues raised by the client at the time of request for transfer; but may not coerce or entice the client to remain with them as a member.

The medical/surgical plan shall assist its PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for clients with special needs, e.g., HIV/AIDS.

Regardless of whether the "good cause disenrollment" is approved or denied, the EBS shall contact the client and assist the client in selecting a PCP or medical/surgical plan for herself and her unborn/newborn. If the client does not select a PCP or medical/surgical plan by forty-five calendar days after the decision, automatic assignment shall occur. The effective date of the transfer is the first of the month possible, given system cutoff.

The EBS shall include:

1. Detailed accounting of the reason for the transfer;
2. Detained plan-provided accounting of the attempt(s) made by the PCP and medical/surgical plan to resolve the issue and work with the client. Before beginning the transfer request
3. Plan-provided documentation that, in spite of reasonable efforts to accommodate the client's medical conditions (physical and behavioral) through service coordination, the client continues to have behavior that is disruptive, unruly, abusive, or uncooperative to the point that his/her continuing participation in managed care seriously impairs the ability of the PCP and medical/surgical plan to furnish services to either the client or others;

4. Plan-provided documentation that the client's behavior has been evaluated to determine if the behaviors are due to a mental illness and whether the condition/behaviors can be treated/controlled through appropriate interventions; or
5. Plan-provided documentation that the PCP and medical/surgical plan has explored appropriate alternatives with the client, and a recommendation as to the most appropriate alternative.

At each step of the process, the EBS shall document the steps taken and inform the client of his/her right to make use of the grievance process or to appeal.

2-002.03E Changes in Eligibility: The EBS will be notified by the Department's interface with the eligibility system if the client's NHC status changes (e.g., mandatory to excluded). Each change in status may require the EBS to contact the client and complete an enrollment for the Basic Benefits Package, unless reenrollment rules apply (see 482 NAC 2-002.03A). (See 482-000-8, Status Change Procedure Guide.)

2-002.03F Follow-Up Contact by the EBS: The EBS shall conduct follow-up until enrollment occurs or the client is automatically assigned to a PCP and medical/surgical plan. The EBS shall make reasonable efforts to contact those clients who have been automatically assigned but who have not had the benefit of an explanation of the NHC.

Follow-up contact may include, but is not limited to, the following:

1. Face-to-face visits;
2. Telephone calls;
3. Home visits;
4. Informational mailings; and
5. After hours/evening meetings.

2-002.03G Priorities for Follow-up Contact: The EBS shall give priority in follow-up contact to the following persons:

1. Pregnant women;
2. Clients with urgent/special needs; and
3. Children age 20 and the younger.

2-002.04 Enrollment Rules: The client or the client's legal representative shall complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:

1. A friend or relative of the client, who does not have legal authority, may complete the informational portion of the enrollment process and health assessment if the individual is determined to have sufficient knowledge of the client's health status;
2. The client or his/her legal representative (i.e., guardian, conservator, or power of attorney (POA) if the POA has this level of authority) shall make the choice of the PCP and medical/surgical plan; and
3. Protection and Safety (PS) staff may act on a Department ward's behalf. The child's foster parents must be involved in the selection of the PCP and medical/surgical plan. PS staff shall consider whether it is appropriate for the biological parents to be involved in the enrollment activity/choice of PCP and medical/surgical plan.

The medical/surgical plan shall not have any direct contact with the client or the client's legal representative, family or friends prior to the client becoming enrolled with the medical/surgical plan, unless the contact is initiated by the EBS in an effort to facilitate the choice of PCP and medical/surgical plan and as it relates to continuity of care issues.

2-002.05 Effective Date of NHC Coverage: The effective date of NHC coverage is the first day of the month following the month during which eligibility is determined and enrollment is completed and activated, given system cutoff. Exception: Hospitalization at the time of enrollment (see 482 NAC 2-002.05D).

2-002.05A Services Before Enrollment in NHC: If eligibility is determined, Medicaid-coverable services received before the month of NHC coverage will be paid on a fee-for-service basis under the rules and regulations of the Nebraska Medical Assistance Program in Title 471 NAC.

2-002.05B Notification of NHC Coverage: The client or the client's legal representative will be notified of NHC coverage and will be issued a notice of finding and NHC Identification (ID) Document by the Department (see 482-000-9, Sample of the NHC Client Notices and ID Document).

The client's status may also be verified through the Nebraska Medicaid Eligibility System (see 471 NAC) or using the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

Through the EBS functions, and written materials and notice, the client will be kept informed of his/her right to change PCP and/or medical/surgical plan.

The medical/surgical plan will be notified of clients enrolled with their medical/surgical plan via a monthly enrollment report (in the form of a data file). The Department electronically transmits the enrollment report to the medical/surgical plan on or before the first day of each enrollment month. The enrollment report provides the medical/surgical plan with ongoing information about its clients and will be used as the basis for the monthly capitation payments (see 482-000-10, Enrollment Report File Layout).

The medical/surgical plan is responsible for providing the NHC Basic Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report will be reported to the Department for resolution. The medical/surgical plan shall continue to provide and authorize services until the discrepancy is resolved. The Department will be responsible for all covered services in the event that a client is eligible for NHC Basic Benefits Package but it is not reflected on the enrollment report.

The Department's Eligibility and Enrollment databases used to build the Enrollment File is the official source of validation in the case of a discrepancy. Once the cause for the discrepancy is identified, the Department shall work cooperatively with the medical/surgical plan to identify responsibility for the client's services until the cause for the discrepancy is corrected. In reconciling the discrepancy, an adjustment will be made in the following manner:

1. If the Department assumes claims payment for the client, the medical/surgical plan shall reimburse the Department for any capitation payment made for that month of service;
2. If the medical/surgical plan assumes claims payment for the client, the medical/surgical plan shall receive a capitation payment; and
3. If the error results in an incorrect amount of capitation payment, the difference will be appropriately reimbursed, either to the medical/surgical plan or to the Department.

The rules for reconciliation and reimbursement shall apply unless specifically addressed elsewhere.

2-002.05C Transition Period: Within the first month of enrollment, the medical/surgical plan is responsible for providing each member general information about the medical/surgical plan, e.g., member handbook, etc.

The medical/surgical plan shall work cooperatively with a client who is experiencing difficulty in transitioning to a managed care environment during the first sixty days of enrollment.

The medical/surgical plan shall continue all services that have been authorized by the Department or the Department's Peer Review Organization (PRO) prior to the client becoming enrolled in the NHC. These services shall be continued until the medical/surgical plan determines that the service no longer meets the definition of medical necessity.

For a client who is specifically identified to have a special need, the medical/surgical plan is responsible for coordinating service needs with the EBS, the PCP, the MH/SA plan and/or provider and the client during the first sixty days of enrollment to ensure a smooth transition into managed health care.

The transitional period may require, but is not limited to, the medical/surgical plan providing additional case management and member services, contracting with out-of-network providers to ensure continuity of care, and taking into consideration the unique needs of the client in understanding and following the managed care rules, e.g., referral and prior authorizations for services.

2-002.05D Hospitalization: When a Medicaid client is an inpatient in an acute care medical/surgical or rehabilitation facility on the day that the client's participation in NHC is effective, the Department remains responsible for the hospitalization until the client is discharged from the facility or transferred to a lower level of care. Authorization for inpatient hospitalizations for rehabilitation services must be obtained from the Department's contracted peer review organization (PRO).

The medical/surgical plan is responsible for a NHC client, who is an inpatient for acute medical/surgical or rehabilitation services on the first of the month that the Medicaid eligible client is no longer enrolled in a medical/surgical plan (i.e., disenrolled) until the client is discharged from the facility or transferred to a different level of care (see 482-000-11, Hospitalization Procedure Guide).

2-002.06 Automatic Assignment for the Basic Benefits Package: All enrollment activities must be concluded within forty-five calendar days. If a choice of PCP and medical/surgical plan is not made, automatic assignment occurs. The client will be automatically assigned to a PCP and medical/surgical plan, based on criteria established by the Department (see 482-000-12, Auto-Assignment Procedure Guide).

The Department provides a report to the EBS prior to the effective date of the auto-assignment enrollment. The EBS shall complete any necessary transfers if an incorrect or inappropriate assignment is identified.

Auto-assignment of a client is indicated on the medical/surgical plan's Enrollment Report.

The Department's auto-assignment algorithm gives priority to provider-client proximity and shall maintain family members with the same PCP and medical/surgical plan, if appropriate.

For a client in the Blind/Disabled and Department Ward/Foster Care categories, the EBS shall facilitate an assignment by pre-nominating a PCP and medical/surgical plan by taking into consideration eligibility and claims history information known about the client (see 482 NAC 2-002.03B).

The Department attempts, but does not guarantee, an equal distribution of clients to available medical/surgical plan during auto-assignment.

2-003 Transfers: A transfer is a change in a client's enrollment from one PCP to another PCP or from one medical/surgical plan to another. A transfer may be made at the client's request (482 NAC 2-003.01) or at the PCP and medical/surgical plan's request (482 NAC 2-003.03). A transfer may also be made because the client requires an Interim PCP (482 NAC 2-003.03E) (see 482-000-13, Transfer and Interim Primary Care Physician (PCP) Procedure Guide).

2-003.01 Client Transfer Requests: The client shall contact the EBS to request a transfer. A client may request a transfer at any time. The transfer will be effective the month following the request but no later than the second month following the request, given system cutoff. The EBS shall assist the client in selecting a new PCP or medical/surgical plan by:

1. Discussing the reasons for transfer with the client and attempting to resolve any conflicts when in the client's best interest;
2. Reviewing the client's needs to facilitate the client's choice of PCP or medical/surgical plan; and
3. Forwarding home health and other critical care services information to the "new" medical/surgical plan within 24 hours of the date of request or effective date of transfer, to facilitate a smooth transition of services prior to the effective date of transfer.

The EBS shall process the transfer and enter the information in the Managed Care File (see 482-000-5). A notice is issued by the Department to the client or his/her legal representative when the transfer is completed. The PCP and medical/surgical plan will be notified via the monthly Enrollment Report (see 482-000-10).

The medical/surgical plan may work with the EBS to resolve any issues raised by the client at the time of request for transfer but may not coerce or entice the client to remain with them as a member.

2-003.01A Exception: When requested by the client, the mother and unborn/newborn may be enrolled in separate medical/surgical plans based on good cause. Good cause includes, but is not limited to, situations in which one medical/surgical plan is unable to meet the needs of both clients.

The request for enrollment in separate medical/surgical plans must be submitted to the EBS, who gathers any additional information needed. The request is then submitted to the Department within two working days. The Department shall approve or deny the request within five working days. The client, PCP and the medical/surgical plan are notified of the approval or denial of the request (see 482 NAC 2-002.03D).

2-003.02 EBS Responsibilities: The EBS shall also discuss the following:

1. The importance of maintaining a medical home;
2. How the client's medical care may be affected by the transfer and what the client's responsibility is in obtaining new referrals or authorizations;
3. That outstanding services may require additional referrals/authorizations in order to maintain the continuation of medical care; and
4. That services approved or authorized by one PCP and medical/surgical plan is no guarantee of approval/authorization of the same services with the new PCP and medical/surgical plan.

If a client is requesting a transfer, the EBS should carefully document the reason. If the client indicates that the PCP has requested a transfer, the EBS should ask the client whether s/he wants to stay with the PCP or not. If the client wants to stay with the PCP, the EBS will request that the medical/surgical plan complete a PCP Requested Transfer before the transfer is completed. The medical/surgical plan shall use Form NHC-6, Transfer Information Form, to request a PCP Requested Transfer from the medical/surgical plan.

If the client does not want to stay with the PCP, the client's request will be honored. The medical/surgical plan will share any information to date with the EBS. At this point, the medical/surgical plan may stop any further activity on the PCP Requested Transfer. The EBS shall use Form NHC-6, Transfer Information Form, to coordinate and request transfer information from the medical/surgical plan.

The EBS will utilize a checklist to ensure all elements of education are discussed with each client.

The EBS shall not discourage a client from completing the transfer; rather, guide the client in exploring his/her options.

The EBS shall process the transfer and enter the information on the Managed Care File (see 482-000-5). The Department shall issue a notice of finding to the client or his/her legal representative when the transfer is completed; the PCP and medical/surgical plan will be notified via the enrollment report.

If the client does not select a new PCP or medical/surgical plan, the client will remain with the existing PCP and medical/surgical plan.

Any transfer for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-20).

In limited situations, when a PCP cannot provide care for a client, the medical/surgical plan shall arrange for an interim PCP within a given month of enrollment. These transfers are handled on a case-by-case basis between the EBS, the medical/surgical plan, and the client and are considered a "client requested" transfer.

The PCP and medical/surgical plan shall maintain responsibility for providing the NHC benefits to the client until a transfer is completed.

The medical/surgical plan may work with the EBS to resolve any issues raised by the client at the time of request for transfer; but may not coerce or entice the client to remain with them as a member.

2-003.03 Primary Care Physician (PCP) or Medical/Surgical Plan Transfer Requests: The PCP or medical/surgical plan may request that the client be transferred to another PCP or medical/surgical plan, based on the following or similar situations:

1. The PCP or medical/surgical plan has sufficient documentation to establish that the client's condition or illness would be better treated by another PCP or medical/surgical plan;
2. The PCP or medical/surgical plan has sufficient documentation to establish that the client/provider relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
3. The individual physician retired, left the practice, died, etc.;
4. Travel distance substantially limits the client's ability to follow through the PCP services/referrals; or
5. The PCP or medical/surgical plan has sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of the NHC service by the client.

The medical/surgical plan shall provide documentation showing attempts were made to resolve the reason for the transfer request through contact with the client or his/her legal representative, the PCP, or other appropriate sources.

The medical/surgical plan shall document that accommodating the needs of the client would create an undue burden on the PCP and medical/surgical plan. Such documentation shall include, but is not limited to, the following:

1. The medical/surgical plan does not have any PCPs in its network with special qualifications, as demonstrated by objective credentialling standards and standards for the care and management, to treat a particular condition;
2. The medical/surgical plan has made reasonable efforts to locate another PCP within its network;
3. The PCP has demonstrated that s/he does not have the requisite skills and training to furnish the care and that s/he has made reasonable efforts to attempt to enlist additional consultation; and
4. The PCP is unable, based on objective evidence, to establish a relationship with a client.

The PCP and medical/surgical plan shall maintain responsibility for providing the NHC benefits to the client until a transfer is completed.

The medical/surgical plan shall assist its PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for clients with special needs, e.g., HIV/AIDS.

The PCP and medical/surgical plan shall not request a transfer due to an adverse change in the client's health, or adverse health status.

2-003.03A Procedure for PCP and Medical/Surgical Plan Transfer Requests: The following procedure applies when a PCP and medical/surgical plan requests a transfer:

1. The PCP and medical/surgical plan shall contact the EBS and provide documentation of the reason(s) for the transfer. The medical/surgical plan is responsible for investigating and documenting the reason for the request. Where possible, the medical/surgical plan shall provide the PCP with assistance to try to maintain the medical home;
2. The EBS shall review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
3. The EBS shall submit the request to the Department within ten days of the request;
4. The Department approves or denies the request for transfer within five working days and responds to the EBS; and
5. The EBS shall enter the Department's decision in the Managed Care File. The client, PCP and medical/surgical plan are notified of the approval or denial of the transfer.

If a transfer is approved, the EBS shall contact the client and assist the client in selecting a new PCP or medical/surgical plan. If the client does not select a PCP or medical/surgical plan by forty-five calendar days after the decision, automatic assignment shall occur. The effective date of the transfer is the first of the month possible, given system cutoff.

Form NHC-5, Nebraska Health Connection PCP Requested Transfer, is utilized for PCP and medical/surgical plan requested transfers.

2-003.03B PCP and Medical/Surgical Plan Requirements: A PCP and medical/surgical plan requested transfer will be investigated by the medical/surgical plan. The PCP may request that the client be transferred to another PCP or medical/surgical plan, based on the following or similar situations:

1. The PCP and medical/surgical plan has sufficient documentation to establish that the client's condition or illness would be better treated by another PCP and medical/surgical plan;
2. The PCP and medical/surgical plan has sufficient documentation to establish that the PCP/client relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc. (This does not include a situation where a PCP has terminated a PCP-client relationship prior to managed care, unless the PCP can establish that the reason(s) for termination still remain an issue.);
3. Travel distance for the client must substantially limit his/her ability to follow through with the PCP's services referral; or
4. The PCP and medical/surgical plan have sufficient documentation to establish fraud or forgery, or evidence of unauthorized use/abuse of NHC services by the client.

The above reasons shall not include a situation where a PCP has terminated a PCP-client relationship prior to managed care, unless the PCP can establish that the reason(s) for termination still remains an issue. The criteria for terminating a Medicaid client from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid clients.

The PCP and medical/surgical plan shall provide documentation that attempts were made to resolve the PCP-client issues through contact with the client or his/her legal representative, the medical/surgical plan or the EBS.

2-003.03C Required Documentation: Documentation shall include the following:

1. Detailed accounting of the reason for the transfer;
2. Detailed accounting of the attempt(s) made by the PCP and medical/surgical plan to resolve the issue and work with the client. Before beginning the transfer request process, the PCP and medical/surgical plan shall make a serious effort to resolve the problem presented by the client, including warning him/her that his/her continued behavior may result in transfer. The medical/surgical plan shall offer to discuss the problem and any potential solution with the client, or employ the plan's internal grievance procedure, or both;
3. Documentation that, in spite of reasonable efforts to accommodate the client's medical conditions (physical and behavioral) through service coordination, the client continues to have behavior that is disruptive, unruly, abusive, or uncooperative to the point that his/her continuing participation in managed care seriously impairs the ability of the PCP and medical/surgical plan to furnish services to either the client or others;
4. Documentation that the client's behavior has been evaluated to determine if the behaviors are due to a mental illness and whether the condition/behaviors can be treated/controlled through appropriate interventions; or
5. Documentation that the PCP and medical/surgical plan has explored appropriate alternatives with the client, and a recommendation as to the most appropriate alternative.

At each step of the process, the medical/surgical plan shall document the steps taken and inform the client of his/her right to make use of the grievance process or to appeal.

The PCP and medical/surgical plan shall maintain responsibility for providing the basic benefits package to the client until a transfer is completed.

2-003.03D EBS Involvement: The medical/surgical plan shall forward documentation of the reason(s) for transfer to the EBS, along with Form NHC-5, Nebraska Health Connection PCP Requested Transfer, for review. The EBS shall conduct any additional inquiry to clearly establish the reason(s) for the transfer by insuring that -

1. The documentation is complete and includes all pertinent EBS contacts with the medical/surgical plan, PCP and/or client;
2. The request includes a recommendation from the EBS regarding viable alternatives for the client, based on a contact with the client; and
3. The request is accompanied by the EBS assessment of the positive/negative effects on the client's continuity of care specific to an approval or denial of the request.

The EBS shall submit the request to the Department within ten days of the request and the Department shall approve or deny the request within five working days.

If the transfer is approved, the Department shall issue notification to the client. The EBS shall contact the client and assist the client in selecting a new PCP or medical/surgical plan. If the client does not select a PCP or medical/surgical plan, the medical/surgical plan shall follow the procedures for Interim PCP Assignment (482 NAC 2-003.03E).

If the transfer is denied, the Department shall issue notification to the client. See 482 NAC 7-000 for the client's grievances/appeals process.

The Department shall notify the PCP and medical/surgical plan regarding the reason(s) for the approval/denial of the transfer request.

2-003.03E Interim PCP Assignment: The medical/surgical plan will be responsible for assigning an Interim PCP in the following situations:

1. The PCP has terminated his/her participation with the medical/surgical plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care;
2. The PCP is still participating with the medical/surgical plan but is not participating at a specific location, i.e., change in location only; or
3. A PCP/plan initiated transfer has been approved (482 NAC 2-003.03A) but client does not select a new PCP.

In all situations, the medical/surgical plan is responsible for ensuring a smooth transition for the client through the assignment of an "Interim PCP."

The medical/surgical plan shall immediately notify the client, by mail or by telephone, that the client is being temporarily assigned to another PCP within the same medical/surgical plan and that the new PCP will be responsible for meeting the client's health care needs until a transfer can be completed/activated by the EBS.

2-003.03E1 Client Notification: The notification sent to client by the medical/surgical plan shall include the following information:

1. Client name, address and Medicaid number;
2. Reason for the change;
3. Name, address and telephone number of the new PCP;
4. Notification that the client has fifteen working days to contact the EBS if s/he wishes to change the temporary PCP assignment and/or affiliation with the medical/surgical plan. If the client does not contact the EBS to effect a change, the temporary PCP will ”automatically" become permanent; and
5. Information on how to contact the EBS.

If a PCP changes location, the medical/surgical plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location. The medical/surgical plan shall notify the client of the change in location. If the client is not satisfied with the PCP's new location, s/he can request a new PCP in a different location, within the allowed fifteen days.

Exception: If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the Nebraska Medicaid client, the PCP should be treated as a terminated PCP.

A sample of the Interim PCP Assignment letter is included in see 482-000-13. The medical/surgical plan shall utilize a similar format that is approved by the Department.

2-003.03E2 Department and Medical/Surgical Plan Coordination: The actual transfer of the client from the client's current PCP to the medical/surgical plan-designated Interim PCP will be accomplished by the medical/surgical plan and the Department via an exchange of information that will systematically be loaded into the Managed Care File by the Department. This information will be provided by the medical/surgical plan to the Department at the time the client letter is sent out. The Department shall process the transfer immediately upon receipt of the information the first month possible, given system cutoff. The client can change the "interim" transfer at any time by following standard transfer procedures.

If a PCP changes location, the medical/surgical plan, after considering the needs of the client, may use its judgment in determining whether the client should be moved with the PCP or remain with a different PCP at the same location.

If the PCP has actually moved out of state, and the PCP is no longer within coverage distance to the client, the PCP will be treated as a terminated PCP.

The Department, based on a termination date on the Provider Network File, shall automatically change the name of the PCP on the NHC Identification (ID) Document, on the Nebraska Medical Eligibility System (NMES), and on the standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271) to indicate "Call your plan" (see 471 NAC). This shall allow the medical/surgical plan to work with the client in applying the interim PCP regulations, if applicable.

If a medical/surgical plan becomes aware of a client's desire to change the PCP and/or medical/surgical plan, the client will be referred to the EBS. The medical/surgical plan may assist the client in contacting the EBS, but shall not be involved in the client's choice.

The EBS is not required to contact the client during the fifteen working days. The fifteen days will be based on the date of the client notification. The actual transfer to the Interim PCP is accomplished by the medical/surgical plan and the Department via an exchange of transfer information that will be systematically loaded into the Managed Care File by the Department. The information will be provided by the medical/surgical plan to the Department at the time the client letter is sent out.

The effective date of transfer to the Interim PCP will be the first month possible, even if this is prior to the fifteen working day notification period.

In situations where a provider changes his/her Medicaid provider number, the medical/surgical plan is not required to notify the client. The Department shall automatically make the change from the old number to the new number, as soon as the number change is identified, i.e., on a nightly basis. NOTE: An automated transfer will occur when a provider changes his/her Medicaid provider number, within the Medicaid provider system. This type of transfer is transparent to the client, if the provider has not made any other changes.

2-003.04 Hospitalization During Transfer: When an NHC client is hospitalized as an inpatient for medical/surgical or rehabilitation services on the first day of the month a transfer to another medical/surgical plan is effective, the medical/surgical plan which admitted the client to the hospital is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) until an appropriate discharge from the hospital or for sixty days, whichever is earlier. The medical/surgical plan the client is transferring to is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) beginning the day of discharge or on the 61st day of hospitalization following the transfer, whichever is earlier. The medical/surgical plan shall work cooperatively with the EBS and the Department to coordinate the client’s transfer.

2-004 Disenrollment/Waiver of Enrollment: See 482-000-14, Disenrollment/Waiver of Enrollment Procedure Guide.

2-004.01 Disenrollment Due to Eligibility Changes: Disenrollment shall occur automatically in the following situations:

1. The client's Medicaid case is closed or suspended;
2. A sanction is imposed on the client; or
3. The client is no longer mandatory for NHC.

The Department shall notify the client, PCP and medical/surgical plan of the disenrollment/waiver of enrollment. Disenrollment is prospective and is effective the first month possible, given system cutoff.

2-004.01A Hospitalization-Related Disenrollments: Disenrollment from the NHC shall occur automatically in the following situations due to a change in mandatory status for the NHC. If the client is receiving inpatient hospital services at the time of disenrollment, the following rules apply:

1. Disenrollment due to loss of Medicaid eligibility: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services on the first day of a month that the client is no longer eligible for Medicaid benefits, the medical/surgical plan shall not be responsible for services effective the first day of the month the client is no longer Medicaid eligible.
2. Disenrollment due to Medicare eligibility: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services on the first day of the month that the client's Medicare coverage has been entered on the Department's eligibility system and is effective, the medical/surgical plan shall no longer be responsible for the hospitalization effective with the client's disenrollment from NHC.
   The medical/surgical plan is responsible for coordinating benefits with Medicare and is responsible for all applicable coinsurance/copayments until the client's disenrollment from NHC is effective.
3. Disenrollment due to transplant: All services provided to the NHC client from the day of the prior-authorized transplant or the day that preparatory treatment (chemotherapy or radiation therapy) for bone marrow transplants begins will be reimbursed to the provider on a fee-for-service basis by the Department. The medical/surgical plan shall notify the Department of the date of the transplant.
   The Department shall initiate disenrollment of the client from NHC. The Department's eligibility system shall reflect the client's disenrollment from NHC the first month possible, given system cutoff. Transplant recipients are permanently excluded from NHC participation. If it is known at the time of enrollment that the client is a transplant recipient, the client will be granted a waiver of enrollment (see 482-000-15, Transplantation Procedure Guide).

4. Disenrollment due to Medical Status Change: When an NHC client is receiving inpatient acute medical/surgical or rehabilitation hospital services and is disenrolled from NHC due to a medical status change (e.g., the level of care the client requires changes from acute care services to custodial care), the medical/surgical plan is responsible for the hospitalization and all related services in the Basic Benefits Package until an appropriate discharge from the hospital occurs or for sixty days, whichever is earlier.
   If the client is to be transferred to another level of care (e.g., acute rehabilitation, home health, etc.) when discharged from the hospital, the medical/surgical plan shall inform the provider of service that the client is no longer participating in NHC and shall instruct the provider to contact Department's contracted Peer Review Organization (PRO) for certification and authorization of services, as appropriate.
5. Disenrollment due to eligibility category change: When an NHC client is receiving inpatient for acute medical/surgical or rehabilitation hospital services is disenrolled from NHC due to an eligibility status change (e.g., the client is no longer in a mandatory group for NHC participation), the medical/surgical plan is responsible for the hospitalization and related services in the Basic Benefits Package until an appropriate discharge from the hospital occurs or for sixty days, whichever is earlier.
   If the client is to be transferred to another level of care (e.g., acute rehabilitation, home health, etc.) when discharged from the hospital, the medical/surgical plan shall inform the provider that the client is no longer participating in NHC and shall instruct the provider to contact the Department's contracted PRO for certification and authorization of services, as appropriate.

2-004.02 Disenrollment/Waiver of Enrollment Due to Special Circumstance: The Department shall manually disenroll/waive the client in the following situations by entering the disenrollment/waiver of enrollment in the Managed Care File (see 482-000-5):

1. The client is a transplant recipient (see 482-000-15); or
2. The client is residing out of the designated coverage areas and the Department determines it is no longer appropriate for the client to remain in the Basic Benefits Package of the NHC.

The disenrollment is prospective and is effective the first month possible following the decision, given system cutoff. A waiver of enrollment occurs prior to any enrollment activities being completed.

Only the client may request a disenrollment, or waiver of enrollment. The disenrollment or waiver of enrollment, if approved, applies until the reason for the disenrollment or waiver of enrollment no longer applies.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

The Department shall notify the client of the disenrollment/waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis.

The Department shall report all disenrollments to the medical/surgical plan on the enrollment report.

2-004.02A Disenrollment/Waiver of Enrollment for Pregnant Woman: The Department shall manually disenrollment/waive enrollment by entering the disenrollment/waiver of enrollment on the Managed Care File (see 482-000-5) for a client whose mandatory status for NHC begins in her third trimester of pregnancy and who is seeking care from a provider (i.e., primary care physician or hospital) not affiliated with a medical/surgical plan, or is affiliated with a medical/surgical plan but is closed to new enrollment.

A waiver of enrollment occurs prior to any enrollment activities being completed.

Disenrollment (i.e., due to an enrollment where pregnancy is not known, such as auto-assignment) or waiver of enrollment requests can only be made by the client and/or the EBS.

The disenrollment/waiver of enrollment is effective until the reason for the waiver of enrollment no longer applies. In the case of a pregnant woman, this provision would apply through the postpartum period, defined as the end of the month in which the 60th day following the end of the pregnancy occurs.

If the request is submitted to the EBS, the EBS shall submit the request, including required forms and documentation, to the Department within two working days of the request. The Department shall enter the waiver of enrollment the first month possible, given system cutoff.

The Department shall enter the status of the request in the Managed Care File. Note: The client may be disenrolled from the Basic Benefits Package and/or Mental Health/Substance Abuse (MH/SA) components of the NHC.

The Department shall notify the client of the disenrollment/waiver of enrollment, whether s/he is waived from the Basic Benefits Package and/or the MH/SA components, and whether s/he shall remain eligible for Medicaid on a fee-for-service basis.

The Department shall report all disenrollments to the medical/surgical plan on the enrollment report.

2-004.02B General Requirements: The client shall contact the EBS to request a disenrollment/waiver of enrollment. If the client is currently enrolled in managed care at the time of the request, the EBS will work with the client to attempt to resolve the reason(s) for the client's request, if applicable. At a minimum, the EBS shall:

1. Explore the reason(s) for the client's request;
2. Review the client's status at the time of enrollment to ensure the current enrollment adequately addresses the client's situation, e.g., nurses notes, health assessment, type of enrollment, etc.;
3. Provide the client with information/education regarding managed care;
4. Explain the regulatory provisions to participate in managed care, and the limited provision for granting disenrollments; and
5. Explore viable alternatives within NHC.

If the client is not yet enrolled in managed care at the time of the request, the EBS will work the client to complete the enrollment activities, including completion of the health assessment.

If it is not possible to resolve the client's concerns, the EBS will proceed with processing a formal client request for disenrollment/waiver of enrollment that includes the following information:

1. Documentation of the activities completed with the client in steps 1-5 above, and with the PCP and medical/surgical plan, to resolve the client's concern(s), including the reason the client has requested a disenrollment;
2. The written request from the client, if the request was submitted in writing;
3. Information from the PCP regarding his/her recommendation for or against the disenrollment/waiver of enrollment with supporting information/documentation for this recommendation; and
4. An independent EBS assessment of the client's current medical/social situation, including the reason the client wants the disenrollment/waiver of enrollment, the attempts at resolving the situation, the results of these attempts, all viable alternatives both within and outside managed care with expected outcomes of each.

The EBS shall forward all of the above documentation to the Department (ATTN: Managed Care Unit) on Form NHC-7, Request for Disenrollment/Waiver of Enrollment Form, within two working days of the request/completed documentation. The Department shall approve or deny the disenrollment/waiver of enrollment within five working days.

The EBS shall make reasonable efforts to obtain documentation from the physician(s) providing care to the client prior to submitting the request to the Department but shall not delay submission of the request for more than ten working days.

For a client who is already enrolled, the effective date of disenrollment/waiver of enrollment is the first day of the month following the decision and no later than the second month. The Department will manually remove the client from "mandatory" managed care status.

A client may be disenrolled or waived out of one or both NHC components: the Basic Benefits Package and/or the Mental Health/Substance Abuse Package.

Some disenrollments/waivers of enrollment are permanent, e.g., transplantation; while others will be approved for a specified period of time, e.g., pregnancy-related. These time limits will be identified on the client's Notice of Finding, and will be reported to the EBS. As appropriate, the Department will monitor the duration of the approval.

The Department shall coordinate any Department-initiated request for disenrollment/waiver of enrollment with the EBS. The EBS will work with the client in exploring resolution to the issue, prior to processing the request.

A Notice of Finding will be issued to the client indicating whether the request for disenrollment/waiver of enrollment was approved. For a client who is already enrolled in managed care, the client's PCP and medical/surgical plan will receive notification of the disenrollment on the monthly Enrollment Report (see 482-000-10).

For a client who is not enrolled, notification to the PCP and medical/surgical plan is not required.

In some cases, the decision to deny/approve the request for disenrollment/waiver of enrollment will be delayed, for up to two weeks, pending receipt of additional information. If no further documentation is received, the request for disenrollment/waiver of enrollment will be denied for lack of sufficient documentation.

The disenrollment/waiver of enrollment applies until the reason for the disenrollment/waiver of enrollment is no longer applicable. The duration of the disenrollment/waiver of enrollment will be monitored on a periodic basis by the Department.

Nothing precludes the client from requesting subsequent request should his/her situation change substantially. The client may also file an appeal of the decision pursuant to 482 NAC.

2-004.04 Admission to Nursing Facility Care: Admission to a nursing facility may affect the client's enrollment in NHC. The following rules apply:

1. When a NHC client is admitted to a nursing facility, the medical/surgical plan shall determine the level of care the client requires - skilled/rehabilitative or custodial/maintenance - using Medicare's definition of skilled care.
   When the level of care the client requires is skilled/rehabilitative, the client shall not be disenrolled from the NHC. The medical/surgical plan shall be responsible for the client while in skilled level of care.
2. When the client is admitted to a nursing facility for custodial care, the Department shall assume financial responsibility for the facility charges. All services included in the Basic Benefits Package will be the responsibility of the medical/surgical plan until disenrollment of the client from the NHC.
3. Disenrollment from NHC shall occur the first month possible, given system cutoff, or first of the month the Department and the medical/surgical plan agree that the client's level of care is custodial, whichever is earlier.
4. When the client is admitted to a nursing facility for custodial care and the client's PCP does not see patients at the facility, the medical/surgical plan shall work cooperatively with the client and the nursing facility to locate a PCP for the client. The medical/surgical plan shall make arrangements to ensure reimbursement of PCP services provided by the client's nursing facility physician, for referrals, and for all services included in the Basic Benefits Package until the client is disenrolled from the NHC, or effective with the first of the month the Department and medical/surgical plan agree that the client's level of care is custodial, whichever is earlier.
5. Transportation services are included in the nursing facility's per diem for most medical services.
6. Clients residing in a nursing facility in an assisted living situation, at a domiciliary or room and board rate, are not residents of the nursing facility. These clients receive room and board only. Clients receiving room and board services in a nursing facility shall not be disenrolled from NHC unless the medical/surgical plan determines that custodial care is appropriate.

For purposes of the NHC, skilled nursing services are those nursing facility services provided to eligible clients which are skilled/rehabilitative in nature as defined by Medicare and the nursing facility admission is expected to be short term. Custodial services are those nursing facility services as defined in 471 NAC and the nursing facility admission is expected to be of long term or permanent duration.

(See 482-000-16, Nursing Facility Procedure Guide.)